THE CHILD AND ADULT CARE FOOD PROGRAM
HOUSEHOLD SIZE—INCOME STATEMENT (CHILD CARE COMPONENT) (FFY 2015, Rev. 7/14)
An adult household member must complete and return to center.

First and Last Name(s) of Enrolled Child(ren)	Center

PART 1: BENEFITS

If any member of your household currently receives FoodShare Wisconsin, Wisconsin Works Cash Benefits, and/or FDPIR (Food Distribution Program on Indian Reservations), **check the box for the benefit currently received and provide the case number. Complete PART 3 and return it to the center's office. Do not complete PART 2. If no one receives these benefits, go to PART 2.**

❑ **FoodShare Wisconsin (10 or 16 digit #)** ❑ **Wisconsin Works Cash Benefits (10 digit #)** ❑ **FDPIR (9 digit #)**
Case Number/Quest Card Number: ______________________________

PART 2: TOTAL HOUSEHOLD SIZE AND INCOME

1) List all household members, including yourself and all children.
2) List all gross income (before deductions or taxes, social security, etc) on the same line as the person who receives it. (Self-employed household members should report net income.) Check the box for how often it is received. Record each income only once.
If you provided a case number in Part 1, you do not need to provide income information.

1) Full Name	Check if Foster Child	2) Gross Income and How Often it Is Received: Earnings from work before deductions	Weekly	Every 2 Weeks	Monthly	Annually	Welfare Payments, Child Support , and/or Alimony	Weekly	Every 2 Weeks	Monthly	Annually	Pensions, Retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Monthly	Annually	All Other Income Received Last Month (indicate frequency)	Check if no income
	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐		☐	☐	☐	☐	$ /____	☐
	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐		☐	☐	☐	☐	$ /____	☐
	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐		☐	☐	☐	☐	$ /____	☐
	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐		☐	☐	☐	☐	$ /____	☐
	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐		☐	☐	☐	☐	$ /____	☐
	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐		☐	☐	☐	☐	$ /____	☐

PART 3: ALL HOUSEHOLDS

Ethnicity and Race Data Collection – *Completion is optional*
This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? ❑ Yes, Hispanic or Latino ❑ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Asian ❑ Native Hawaiian or Other Pacific Islander

ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)

If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# or check "None" if you do not have a SS#.

I CERTIFY that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on this form; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult Household Member	Signature Date *Mo./Day/Yr.*	Last 4 digits of SS# (or check "None" if you do not have a SS#)
		***-**-__ __ __ __ ❑ None

FOR CENTER USE ONLY – All 3 sections and the Effective Date must be completed

1) Basis of Determining Eligibility	2) Eligibility Determination	3) Determining Official's Initials & Approval Date
❑ Total Household Size ________ Total Income $________/_____ OR ❑ FoodShare WI ❑ W-2 Cash Benefits ❑ FDPIR ❑ Foster Child(ren)	❑ Free ❑ Reduced ❑ Non-Needy	______________________ **Effective Date of the Determination** ______________________

Use the following conversion factors to determine yearly income only when multiple pay frequencies are reported: Weekly income x 52 = Yearly income. Every 2 weeks income x 26 = Yearly income. Twice a month income x 24= Yearly income. Monthly income x 12= Yearly income.
This form expires one year from the agency's chosen effective date, as indicated in its CACFP online application.

Wisconsin Department of Public Instruction
CACFP ENROLLMENT FORM
PI-6077 (Rev. 06-13)

Parent/Guardian Instructions:

Use a separate form for each enrolled child. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child, to meet the annual updating requirements.**

GENERAL INFORMATION

Child's Name	Child Care Facility	Child's Age

HOURS AND MEALS WHILE IN CARE

Days Normally in Care (Check ✓)	Hours Normally in Care				Meals Normally Received While in Care (Check ✓)					
	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
☐ Sunday					☐	☐	☐	☐	☐	☐
☐ Monday					☐	☐	☐	☐	☐	☐
☐ Tuesday					☐	☐	☐	☐	☐	☐
☐ Wednesday					☐	☐	☐	☐	☐	☐
☐ Thursday					☐	☐	☐	☐	☐	☐
☐ Friday					☐	☐	☐	☐	☐	☐
☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 1

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 2

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

PARENT LETTER

PARENT LETTER FOR THE CHILD AND ADULT CARE FOOD PROGRAM
(CHILD CARE COMPONENT) NON-PRICING PROGRAM (FFY 2014)

Dear Parent or Guardian:

The La Casa de Esperanza, Inc. serves nutritious meals without an additional
(Name of Sponsoring Organization)

charge because the center receives added reimbursement for each child whose household income is at or below the level shown on the household size-income scale below. In order to continue this meal service without an additional charge to you, please complete and return the attached application. This information is kept confidential in our files, and is required to determine the appropriate rate of reimbursement under the Child and Adult Care Food Program. If your income is higher than the amount indicated below for your household size, you do not need to complete the application. Once properly approved for free or reduced price benefits, a household will remain eligible for those benefits for a period not to exceed 12 months.

(Effective July 1, 2013 to June 30, 2014)

Household Size	Monthly Income Level (at or below)
1	$1,772
2	2,392
3	3,011
4	3,631
5	4,251
6	4,871
7	5,490
8	6,110
For each Additional Household Member, Add	+620

Households with incomes less than or equal to the reduced-price standards would be eligible for free or reduced price meal benefits. Participants having family members who become unemployed are eligible at the higher rate during the period of unemployment provided that the loss of income during the period of unemployment causes the household income to be within the eligibility guidelines indicated above.

When eligibility is established by household size and income, a complete application must include: (a) names of all household members including the name of the child applicant; (b) the last four digits of the social security number of the adult household member signing the application or an indication that the household member does not have a social security number; (c) household income received by each household member identified by source of income; and (d) the signature of an adult member of the household and date signed.

When eligibility is established by the Supplemental Nutrition Assistance Program (SNAP) (FoodShare Wisconsin) case number, FDPIR case number, or W-2 Cash Benefits number, a complete application must include: (a) the name of the child applicant; (b) the appropriate SNAP (Food Share Wisconsin), FDPIR or W-2 Cash Benefits case number for the child; and (c) the signature of an adult member of the household and date signed. Eligible W-2 Cash Benefits programs are Trial Job, Community Service Job (CSJ), Caretaker of an Infant (CMC), At Risk Pregnancy (ARP), and W-2 Transition (W-2 T). **DO NOT give numbers for Medicaid, SSI, or W-2 Child Care Assistance.**

Meals served to foster children are eligible for reimbursement at the free price rates regardless of the household's income. A foster child placed in a home may be included as a household member on the same application that includes the non-foster children.

USE OF INFORMATION STATEMENT: Unless a SNAP, FDPIR, or W-2 Cash Benefits case number is provided for your child, you are applying for a foster child, or unless a Head Start statement of income eligibility verification is provided for your child, the Richard B. Russell National School Lunch Act requires that the adult household member signing the application must report his or her last four digits of the social security number on the application. If the adult household member signing the application does not possess a social security number, he/she must indicate so on the application. Provision of the last four digits of the social security number is not mandatory, but if it is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. The last four digits of the social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application for proper administration and enforcement of the Child Nutrition Programs. Your eligibility information provided on the application may be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

Children's free and reduced price meal eligibility information may be shared with other State agencies and other Child Nutrition Programs without prior notification. If your children's meals are reimbursed at the free or reduced price rate, these children may also be able to get free or low-cost health insurance through Medicaid or the State Children's Health Insurance Program (BadgerCare). Because health insurance is so important to children's well-being, **the law allows us to tell Medicaid and BadgerCare that your children's meals are eligible for the higher reimbursement rate(s), unless you tell us not to.** Medicaid and BadgerCare only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children. (Filling out the Household Size-Income Statement does not automatically enroll your children in health insurance.) **If you do not want us to share your information with Medicaid or BadgerCare please notify us in writing. Notification will not change whether or not your children's meals are reimbursed.**

Signature of Sponsor Representative

Child's Schedule
Horario de su hijo/a

Child's name/nombre del hijo/a: _____

Date effective/fecha efectivo: _____

Day/día	Monday/lunes	Tuesday/martes	Wednesday/miércoles	Thursday/jueves	Friday/viernes
IN ENTRADA					
OUT SALIDA					
# hours					

_____ Upon office approval, these are the hours that my child has a secured spot each week in his/her classroom, provided I remain on-track with my payment plan.

_____ I understand that any additional hours may or may not be available due to the scheduling and availability of slots and staff. It is my responsibility to receive APPROVAL IN ADVANCE for any hours outside of this schedule. I understand that I am required to pay for these hours in advance.

_____ It is my responsibility to notify the childcare office promptly if this schedule changes for any reason at any time.

Parent/Guardian Name: _____

Parent/Guardian signature: _____ Date: _____

For Office Use Only

Rate Type: Full Half Hours/week _____ W2 PP

Staff: _____ Date: _____ Entered:

First shift Second Shift Split Shift
School: _____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

Child Enrollment and Health History – Certified Child Care

Use of form: Use of this form is voluntary. However, completion of this form meets the requirements of DCF 202.08(9)(d), 202.08(12)(f) and DCF 202.09(7)(b). If you are both certified and licensed family child care, you are required to use the forms *DCF-F-CFS0062 Child Care Enrollment* and *DCF-F-CFS2345 Health History and Emergency Care Plan*. Failure to comply with program regulations may result in the issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions – Parent / Guardian: The parent / guardian shall fill out the form completely, sign it and submit it to the certified provider prior to the child's first day of attendance. Do not leave any fields blank. If they do not apply, enter "N/A" or "none." The parent / guardian should maintain ongoing communication with the child care to ensure the information on this form is kept current. When enrolling a child under two years of age, a completed *DCF-F-CFS0061-E Intake for Child Under 2 Years – Child Care Centers* must also be on file prior to the child's first day of attendance.

Instructions – Child Care: The completed and signed form shall be obtained prior to the child's first day of attendance, maintained in the child's file on the premises, and available for review by the regulating agency. Review the form to ensure that no fields have been left blank. Pay particular attention to the Birthdate and First Day of Attendance fields, and check to ensure that the form has been signed by the parent and dated. The child care shall maintain a system of communication with the parent / guardian to ensure the information on this form is kept current. A section is available at the end of this form where the child care may record the dates they reviewed or updated the information on the form. When enrolling a child under two years of age, a completed *DCF-F-CFS0061-E Intake for Child Under 2 Years – Child Care Centers* must also be on file prior to the child's first day of attendance.

A. CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

Address – Home (Street, City, Zip Code)	Telephone Number

B. PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.

1. Name and Relationship to Child | Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip) | Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No.

2. Name and Relationship to Child | Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip) | Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No.

C. AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

1. Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

2. Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

D. EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.
Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

E. PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

F. HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. ☐ Yes ☐ No Does your child have any special medical condition? If Yes, check all that apply.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

☐ Food allergies – Specify food(s):

☐ Gastrointestinal or feeding concerns including special diet and supplements. If the child has a medical condition, excluding food allergy, that requires a special diet including nutrient concentrates and supplements, attach the written authorization from the child's physician.

☐ Non-food allergies – Specify:

☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ Asthma

☐ Cerebral palsy / motor disorder

☐ Diabetes

☐ Epilepsy / seizure disorder

☐ Other condition(s) requiring special care – Specify:

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medication is necessary, parental authorization is required and should be attached. The form *DCF-F-CFS0059-E Authorization to Administer Medication – Child Care Centers* may be used by certified programs to comply with DCF 202.08(4)(f).

5. When to call parents regarding symptoms or failure to respond to treatment.

6. When to consider that the condition requires emergency medical care or reassessment.

7. Additional information that may be helpful to the child care provider.

G. AUTHORIZATION – SUNSCREEN / INSECT REPELLENT – If provided by the parent / guardian, the sunscreen or insect repellent shall be labeled with the child's name. Authorizations shall be reviewed periodically and updated as necessary.

1.	☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.	Sunscreen Brand Name	Ingredient Strength
2.	☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Repellent Brand Name	Ingredient Strength

H. AUTHORIZATION – EMERGENCY MEDICAL TREATMENT

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

I. AUTHORIZATION – FIELD TRIPS / TRANSPORTATION

1. ☐ Yes ☐ No I give permission for my child to be transported to and from the center.
2. ☐ Yes ☐ No I give permission for my child to participate in ☐ **Transported** ☐ **Walking** field trips and other activities during operating hours.
3. ☐ Yes ☐ No I hereby give permission for my school-aged child to enter a building unescorted.

J. ATTESTATION

1. ☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin rules, DCF 202, governing certified child care programs.
2. ☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

K. SIGNATURE

SIGNATURE – Parent or Guardian	Date Signed

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 09/08)

STATE OF WISCONSIN
ss. 252.04,Wis. Stats.

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA **PLEASE PRINT**

STEP 1

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5

To the best of my knowledge this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

Clear Form and Reset

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under age 2 in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: This form is to be completed by a parent and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)	Nickname (If any)	Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)	Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

HEALTH Note: Health conditions that may affect the care of the child must be recorded on the department's form, Health History and Emergency Care Plan. The form should be shared with any person who provides care for the child.

☐ Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule	Length of time on current schedule

Food type
☐ Formula ☐ Strained ☐ Junior ☐ Table ☐ Milk type – Specify:

New food timetable

When eating, child is –
☐ Held in lap ☐ In highchair ☐ Other – Specify:

Feeds self
☐ Yes ☐ No If "Yes", uses: ☐ Spoon ☐ Fork ☐ Hands

Special feeding problems
☐ Yes ☐ No If "Yes" – Specify:

Food allergies
☐ Yes ☐ No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule

Length of time on current schedule

Falls asleep easily
☐ Yes ☐ No

Mood upon awakening – Describe.

Takes favorite toy(s) to bed – **child over age 1 year**
☐ Yes ☐ No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**
Note: Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.
☐ Back for children under age 1 year ☐ Side or stomach (physician statement attached)

Sleep position – **child over age 1 year**
☐ Back ☐ Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper – type
☐ Cloth ☐ Disposable

Diapers provided by parent
☐ Yes ☐ No

Plastic pants used
☐ Always ☐ Never ☐ Sometimes If "Sometimes" – Specify:

Highly sensitive skin
☐ Yes ☐ No

Frequent diaper rash
☐ Yes ☐ No

Lotions, powders or salves used
☐ Yes ☐ No If "Yes", product name(s) – Specify:

Toilet training attempted
☐ Yes ☐ No If "Yes", describe routine.

Type of toilet seat used at home
☐ Potty chair ☐ Special toilet seat ☐ Regular toilet seat

Regular bowel movements
☐ Yes ☐ No How often. Time(s) of day:

Toileting problems
☐ Yes ☐ No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family speaks what language – Specify.
☐ English ☐ Other If "Other" – Specify:

Age child began talking

Child speaks in
☐ Words ☐ Sentences

Words used to describe special needs – Specify.

UPDATES

COMFORTING

Does child have a fussy time?

☐ Yes ☐ No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:

☐ Held ☐ Sung to ☐ Rocked ☐ Read to ☐ Other – Specify:

Special things you say or do to comfort child.

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to – (Check all that apply)

☐ Sit up alone ☐ Pull up ☐ Crawl ☐ Walk holding on ☐ Walk without support

☐ Yes ☐ No Is your child used to playmates?

Comments

UPDATES

MISCELLANEOUS

Child's **indoor** favorite toys and activities – Specify.

Child's **outdoor** favorite toys and activities – Specify.

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

UPDATES

SIGNATURE – Parent or Guardian

Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education
DCF-F (CFS-0056) (R. 12/2008)

STATE OF WISCONSIN

Transportation Permission – Child Care Centers

Use of form: Use of this form is voluntary. However, completion of this form will help ensure compliance with portions of DCF 250.08, DCF 251.08 and DCF 252.09 of the Wisconsin Administrative Codes regarding regularly scheduled, center-provided / center-contracted transportation of children in care to and from the center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file at the center and update the information as needed. The center shall maintain the completed form in the child's file for the duration of the child's enrollment. Note: A copy of this form shall be carried in the vehicle when transporting the child. If the child has special health care needs, also include a copy of CFS-2345, Health History – Child Care Centers.

A. CHILD INFORMATION

Name	Address – Home (Street, City, State, Zip Code)

☐ Yes ☐ No Does the child have any special health care needs? If "Yes", attach the department form, "Health History – Child Care Centers."

B. PARENT / GUARDIAN INFORMATION

Provide information where the parent / guardian may be reached while the child is in care.

	Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
1.				
	Address (Street, City, State, Zip Code)			
2.				
	Address (Street, City, State, Zip Code)			

C. EMERGENCY CONTACT INFORMATION

Provide information on the person to contact if the parent / guardian cannot be reached.

Name	Address (Street, City, State, Zip)	Telephone Number

D. AUTHORIZED DESTINATIONS / PERSONS INFORMATION

	Address Child Transported From (Street, City)	Address Child Transported To (Street, City)	Person Authorized to Receive Child
1.			
2.			
3.			
4.			

Procedure to follow when parent / guardian or authorized adult is not at destination to receive child – Specify.

E. CHILD'S HEALTH CARE PROVIDER INFORMATION

Name – Physician	Address (Street, City, State, Zip Code)	Telephone Number

F. AUTHORIZATION

1. ☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
2. ☐ Yes ☐ No I hereby give permission for my school-aged child to enter a building unescorted.

SIGNATURE – Parent / Guardian	Date Signed

LA CASA
de Esperanza, Inc.

Media Release

Permiso de Publicación para Medios de Comunicación

Regarding promotional use of your child's photograph, please choose one of the following:
Respecto al uso promocional de fotografía, favor de escoger una de las siguientes opciones:

___ I give permission for my child's photograph to be used by La Casa de Esperanza, Inc. for any promotional purposes for including, but not limited to, brochures, newspapers, websites, educational presentations, and/or funding sources.

Yo doy permiso que La Casa de Esperanza, Inc. use una fotografía, de mi hijo(a) para cualquier propósito promocional incluyendo, entre otras, folletos, periódicos sitios de la web, presentaciones, educativas, propósitas de financiación.

___ No I do not give permission for my child's photograph to be used by La Casa de Esperanza, Inc. for any promotional purposes.

No doy permiso que La Casa de Esperanza, Inc. use ninguna foto de mi hijo(a) para cualquier propósito promocional.

_____

Child's Name
Nombre del niño

_____ _____

Parent/Guardian Signature
Firma del padre/custidario

Date
Fecha